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Contents:

HYPNOSIS NUMBER

Menninger Foundation Activities: Hypnosis Research 161

Treatment of a Case of Anxiety Hysteria by an Hypnotic Technique Employing Psychoanalytic Principles. *By* Merton M. Gill, M.D. and Margaret Brenman, Ph.D. 163

The Use of Induced Hypnagogic Reveries in the Recovery of Repressed Amnesic Data. *By* Lawrence S. Kubie, M.D. .. 172

Use of the Rorschach Test in the Prediction of Hypnotizability. *By* Margaret Brenman, Ph.D. and Suzanne Reichard 183

Hypnotherapy for Mental Illness in the Aged: Case Report of Hysterical Psychosis in a 71-year-old Woman. *By* Margaret Brenman, Ph.D. and Robert P. Knight, M.D. 188

Publications by Members of the Staff 199

Book Notices 200

Index to Volume VII 201

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Bulletin of
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VOLUME 7 September-November, 1943 NUMBERS 5 and 6

MENNINGER FOUNDATION ACTIVITIES

HYPNOSIS RESEARCH

There is a general realization on the part of psychiatrists that our present methods of psychotherapy, while increasingly efficacious, are slow and time consuming. This is especially important now that enormous numbers of war neuroses and other psychiatric conditions are being thrown upon the all too meager supply of psychiatrists for treatment. No one has been more aware of this dilemma than the psychoanalysts who, although they possess a highly effective therapeutic technique in psychoanalysis, know from experience that successful treatment by this means requires a period of many months and sometimes several years of consistent and persistent effort. For some time progressive psychiatrists have been striving to find methods of applying psychoanalytic principles to the treatment of the many patients who need psychotherapy in some form that would require less time for the patient and perhaps less extensive technical training for the therapist. There are only a few hundred psychoanalysts in the country and, in addition to these, there are relatively few psychiatrists who are capable of doing effective psychotherapy. To train a psychiatrist to do competent psychotherapy requires several years.

Among the experiments which have been made with forms of effective psychotherapy which require less time, and perhaps less training, than psychoanalysis, one of the most promising would seem to be a modification of hypnosis. This powerful and dramatic method of treatment has long been neglected in psychiatry for a variety of reasons, one of which is that in the form in which it was originally used hypnosis had the serious defect of being transitory in its curative effects. This was one of the difficulties that led Freud to abandon hypnosis in his early work with neurotic patients in favor of the method of free association. But in the past few years the experimental work of Erickson, Kubie, Farber and Fisher, Eisenbud and others has led to a feeling that some of the older difficulties with hypnosis as a therapeutic method could be eliminated by modifications in the technique and the employment of some of the knowledge about the unconscious which has been acquired through psychoanalysis.

At this Clinic, while we have always favored the use of hypnosis in principle, we rarely employed it in practice until our interest was recently revived, partly through discussions with the other workers mentioned, and

partly through the work of one of the newer members of our staff who had been using hypnosis in experimental work. Some further experimental work was pursued here, combining the older techniques of hypnosis with certain procedures derived from psychoanalytic theory and practice. The results in several cases arrested our attention and led us to feel that the possibilities of exploiting this combined hypnotic and psychoanalytic method should be pursued further. The details of this modified method of hypnotic treatment as applied in two cases of this experimental series are reported in this number of the BULLETIN.

Visits from Dr. Frank Fremont-Smith, of the Macy Foundation, Dr. Alan Gregg, of the Rockefeller Foundation, and Dr. Lawrence S. Kubie, of the Subcommittee on War Neuroses of the National Research Council, further encouraged us to proceed with this research. Specific projects were outlined by the Research Committee of The Menninger Foundation with a view to learning more about the deeper dynamics of hypnosis, the type of case to which the technique is most applicable, the best way of learning and teaching the technique, and the relative stability of the cures accomplished. Grants have been made to us for this research by the Josiah Macy, Jr. Foundation, the New York Foundation and the Hofheimer Foundation.

The main research program is ahead of us. To what extent this method can be applied to the more effective treatment of neuroses and psychosomatic disorders occurring in the armed forces and in the civil population, in what ways it will further clarify the essential nature of the phenomenon of hypnosis, in what measure it will yield new information regarding psychosomatic relationships and psychoanalytic concepts, it is much too early to predict but these are some of our collateral hopes from the progress of the work begun. In this issue of the BULLETIN we are presenting some of the preliminary work done so far and a contribution by Dr. Kubie, who is working along similar lines and whose suggestions about our work have been generously given and gratefully received. Further reports of our investigations will be made in a subsequent issue of the BULLETIN.

THE EDITORS

TREATMENT OF A CASE OF ANXIETY HYSTERIA BY AN HYPNOTIC TECHNIQUE EMPLOYING PSYCHOANALYTIC PRINCIPLES*

By MERTON M. GILL, M.D., and MARGARET BRENMAN, Ph.D.

The patient with whom we worked was a conventional middle-class housewife in her middle thirties who was referred to the Menninger Clinic by an internist who had been unable to find any organic basis for her symptoms. She had been ill periodically for seven years, continuously for two years and with marked exacerbation for the preceding six months. The symptoms which concerned her most were daily nausea and vomiting, severe lower abdominal pain, anxiety and depression and trembling of the left hand. There were numerous other symptoms, including headaches, dysmenorrhea, a fear of falling, palpitation and nightmares in which she saw herself being killed or buried.

She gave her history with the vagueness, the many gaps and the placing of the onset of symptoms by successive stages in the more distant past which Freud has described as so characteristic of hysteria.

Although quite intelligent, the patient had a somewhat childlike naiveté. For example, she engaged other patients in the waiting room in conversation about her symptoms and once queried a stranger just outside the Clinic grounds about the work of the Clinic, saying she wanted to be sure that her money was being well spent. She said she supposed this person was another patient who could give her the benefit of his experience.

The history and psychiatric examination pointed unmistakably to a diagnosis of anxiety hysteria. Psychological test findings supported this diagnosis and though she attained an I.Q. of only 100, it appeared that her effective intelligence was diminished by her great anxiety and preoccupation with fantasy.

Psychoanalysis was impracticable in this case for the same reasons that it is so often impracticable. The patient lived 200 miles away, her husband and two children needed her, she was in poor circumstances. She was very eager for help, however, and it was decided to determine whether she would be suitable as a case in the hypnosis research project.

The patient's degree of hypnotizability was determined first. She proved to be an excellent subject and went into a deep trance in the first session. She was permitted to talk at will and began at once to recount a nightmare that she had had the night before, of the sort which constituted

* Read before the Joint Session of the American Psychoanalytic Association and the psychoanalytic section of the American Psychiatric Association in Detroit, Michigan, May 12, 1943.

one of her presenting complaints. This was the beginning of a course of treatment in which the patient was seen every day for an hour to an hour and a half, six days a week for sixty-seven interviews. At first the interviews were conducted chiefly by the author who was experienced in hypnosis (M. B.), later by the author who had worked with the case originally as a psychiatrist (M. G.). Both authors were always present. The interview was always begun with a short session in the hypnotist's office, in which the patient usually described how she had felt during the last twenty-four hours, frequently summarized what she had learned in the previous day's hypnotic session and occasionally advanced new ideas and formulations that had occurred to her since that session. If the patient had dreamed the night before, she usually related this dream in the preliminary interview. The patient was then taken into another room and hypnotized. After the first few hypnotic sessions she was very easily placed in hypnosis simply by the therapist's counting to ten. After the hypnotic session, a few words were occasionally exchanged about how the patient was feeling, she sometimes made some comments upon the material of the hypnotic hour and the appointment was made for the following day. After the first hypnotic session, the patient remarked that to her surprise she was able to remember everything that had gone on in hypnosis. She was reminded that nothing to the contrary had been suggested and thereafter she continued to remember all the material of the hypnotic sessions except in a few instances where amnesia was specifically suggested and in a number of others where the forgotten material proved to have special dynamic significance.

The technique which was followed in the hypnotic sessions was in general one of directed associations. Usually the hour was begun by taking up the topic which, from her pre-hypnotic remarks, appeared to be uppermost in the patient's mind. This was discussed with her until some question was reached which she was unable to answer or to which her answer was unenlightening to the therapists. The formulation which was then most generally applied was "I will count to a certain number and when I reach that number you will tell me the first thing that occurs to you in connection with so-and-so." Variations of this formula were also used. Sometimes the patient was told that a single word would occur, sometimes a picture. When it was particularly difficult to elicit material, she would sometimes be told that a number would occur to her which would indicate the number of letters in a word, and then these letters would be obtained in jumbled order. For example, she was once told that at the count of five, a number would occur to her which would be the number of letters in a word, which would help to answer the question under consideration. The number turned out to be four. The therapist then counted to five to get a letter, which was "m". The other letters obtained similarly were

"o", "b", "w", and the four as re-arranged by the patient spelled "womb." It would frequently take the patient some little time to recognize the word which was constituted by a jumble of letters, even when it was obvious to the therapists. Frequently we would ask the patient to associate to a certain idea by producing an earlier memory which had the same emotional connotations as the idea. These same types of associative techniques were used in the exploration of dreams. We found that the dreams as given in the hypnotic state, in contrast to the pre-hypnotic interview, were much more replete with significant detail through which their meaning could be more quickly learned.

A few specialized hypnotic techniques were also used. On a number of occasions, the patient was told that she would have a dream in connection with a certain problem and this was almost always successful. On several occasions the patient was made in hypnosis to complete an incomplete dream action. In one dream, for example, she searched through an entire house, though she didn't know what she was looking for. The last place in which she was going to look was the basement. But as she began to go down the stairs she awoke in terror. In the hypnotic hour she was made to go down into the basement and describe what she found. On one occasion the technique of induced regression to an earlier age was used with rather striking results. The patient was regressed to the age of five. We asked her where babies came from. She told us that babies were vomited up but refused to tell her theory as to how they were made. That night she had a dream which was a repetition of an experience at the age of five, in which she had been told of fellatio by a little girl friend. She then told us that it was this memory that she had refused to communicate while she was regressed.

The interviews were conducted with a great deal more activity on the part of the therapist than is the case in the usual psychoanalytic interview. The hypnotic interviews at times approximated question and answer interviews, rather than prolonged, uninterrupted, spontaneous verbalization on the part of the patient. The therapists followed whatever lead appeared to be the most promising and if after five or ten minutes it seemed to be yielding nothing, it was abandoned for another topic. Nevertheless, interpretations, except as will later be described with reference to transference phenomena, were kept at a minimum. Most interpretations were merely elaborations of the patient's spontaneous insight. Although it was the therapists' tentative formulations which led them to open certain topics, other psychiatrists who have read the verbatim records of the sessions have agreed that almost always the patient's formulations were spontaneous. This spontaneity was further attested to by the fact that much of the patient's production was unanticipated. The material unfolded with dramatic rapidity and withal in a well-ordered sequence.

Most hours ended with unresolved problems and the patient frequently began the next hour by plunging into the previous day's problem as though the intervening 24 hours were blotted out.

Her freedom of behavior in hypnosis was in vivid contrast to that of the ordinary hypnotic subject as we usually see her in the experimental situation. At first she sat immobile, just as a subject usually does. But one day she moved her arm in describing something. She was startled to find that she had moved it, but when it was pointed out that she had not been prohibited from moving, her behavior became more and more free until soon there were hours when she was pounding on the arms of her chair in furious anger, and other in which she wept in despair, all the while in deep hypnosis. This illustrates what we believe to be one of the most important aspects of the treatment. Hypnosis can take place in a permissive atmosphere in which the patient can be given wide latitude of expression and behavior. Hypnosis can be divested of its time honored implications of the subject's absolute subservience, and immobility, and helplessness to act except under the initiation of the all-powerful hypnotizer.

When we were attempting to explore more adequately a memory that the patient had recalled, we would frequently suggest that the recall would be as vivid as though she were again experiencing the original event. The actions with which the patient accompanied some of her verbalizations attested to the vividness with which she was re-living experiences. When she recalled in hypnosis how she had in a dream searched for something in the sky, she raised her head and moved it as though searching on high, although her eyes remained closed. When she was asked to look into an open grave, which in the dream she had been afraid to do, she craned her head forward with such genuine apprehension and expectation that the effect was quite eerie. She was unaware of such bodily movements and expressed amazement when they were called to her attention. In her verbalization she would switch back and forth in a remarkable way from past to present tense, as though she was at one moment oriented in the present and at the next moment vividly re-living the past. We feel that this intricate interweaving of the past and present represented the re-integration of the repressed past into her conscious ego.

Some of the patient's symptoms disappeared in the manner which Freud described as occurring in cathartic abreaction and it was in connection with these that the experiences of re-living were most vivid. A notable example was her fear of falling which disappeared soon after the beginning of the treatment, immediately after her recall and re-living in hypnosis with intense affect two childhood falling experiences. In one she fell from a high chair and in the second, she fell from a hammock at the age of seven. It is difficult to describe the vividness with which she cried in terror, "Save me, Dr. B., save me—I'm falling!" That this re-living in hypnosis is not

simply a re-living of the original experience but rather a re-living which takes place in the frame of the present personality structure is clearly shown by her calling on the doctor to save her—and indeed it is likely that it is this very difference which permits the resolution of the conversion mechanisms.

Other symptoms disappeared only when their symptomatic meaning had become clear to the patient. The hand-trembling, for example, was not completely relieved until the very end of the treatment when the patient developed what seemed to us to be full insight into its symbolic meaning.

The case material and dynamics which were actually obtained we do not report here. We plan to publish them in detail, but believe that it is more appropriate here to discuss the method rather than the individual case. In brief, it can be said that we obtained the kind of material which is familiar to all psychoanalysts in the psychoanalysis of cases of conversion hysteria. We learned, for example, that the patient's vomiting represented *both* a rejection of impregnation and a fantasy of delivery, *both* of which she unconsciously thought took place by mouth. Material substantiating the psychoanalytic discoveries concerning infantile psychosexual development appeared in unusually clear and abundant detail, not simply in terms of reconstruction on the basis of fantasies, but rather by way of direct recall of childhood memories and ideas. By the end of the treatment the patient had been entirely relieved of her symptoms, not only those of somatic conversion, but also the psychological disturbances, such as her anxiety and depression. Shortly after she returned home her youngest child became seriously ill, and although some of her anxiety returned, she weathered the storm very much better than she had previous similar episodes. This experience, however, has led her to feel that she needs a few more weeks of treatment and she plans to return.

We call the treatment we used "hypnoanalysis" because we believe it combines significant features of hypnosis and psychoanalysis. We should like to discuss how the present method resembles and how it differs from each of these.

One of the basic differences between this treatment and hypnosis as previously used and one of its essential similarities to psychoanalysis is the handling and the use of the transference. Undoubtedly the most significant addition to the technique of psychoanalysis that Freud made after abandoning the hypnotic method in favor of free association was the recognition and the interpretation of the transference. It is now well recognized that the transference phenomenon exists in every psychotherapeutic situation—indeed in every relation between physician and patient and in many other life situations. The unique contribution of psychoanalysis is the awareness of and interpretation to the patient of this trans-

ference. The patient's recognition of his enactment in the psychotherapeutic situation of his previously formed behavior patterns is one of the most important vehicles by which he obtains insight.

Psychoanalysis is no longer the only method which makes conscious use of transference. An attempt has been made by a few psychiatrists to carry over the technique into general psychotherapy and many psychoanalysts believe that when the unconscious mechanisms of the patient-therapist relation are throughly understood by the therapist, any method of psychotherapy can be made more effective.

Although the dynamics of the induction of hypnosis have only begun to be explored, there seems little doubt that there is an intimate relation between the induction of hypnosis and the transference between hypnotizer and subject. This is not to deny that other factors may be involved too. Perhaps the first clear formulation of this point of view was made by Ferenczi who differentiated between "mother" and "father" hypnosis. He believed that the force impelling the subject to accept hypnosis was in the first instance love, and in the second, fear. Ferenczi attributes cures through hypnosis to the persistence in the patient of this unconscious transference. In our patient, the ease of hypnotizability varied with the state of the transference. When she was in an angry, rebellious mood, the hypnosis was somewhat more difficult to induce and was not as deep. When she was in a state of positive transference, she went quickly to sleep, with a deep sigh of unmistakably erotic significance.

We are here not as concerned with the significance of transference in the induction of hypnosis as with the interpretation of the transference as it arose within the hypnotic interviews. That is to say, we made no attempt to interpret the transference by which the patient became hypnotized, but we did interpret the transference which developed in the psychotherapeutic relationship in a manner very similar to that in a psychoanalysis. The patient's transference in this case ran the gamut from warm expressions of affection under the influence of which her symptoms were markedly alleviated simply by her entrance into the therapists' office, to wild outbursts of rage, anger and jealousy. The initial interpretations of the transference were an exception to the general rule that interpretations were not given by the therapist until spontaneously suggested by the patient. After these first interpretations, however, with explanations to the patient of the nature of transference, she spontaneously expressed her insight into the changing aspects of the transference just as she did into the progressive unfolding of the psychodynamics of her neurosis. The specific details of the transference could be given only in the light of the complete treatment history and therefore only a few examples will be given here: The patient vomited instantly when she learned that the psychiatrist's wife had just had a baby. She spontaneously recognized that this

vomiting was based on the same jealousy and wish to have a baby by a father figure that she had felt when her siblings were born. Under the influence of an oral theory of birth she had as a child reacted to their appearance by vomiting. There were several instances of unusual transference behavior arising from the fact that the patient was being treated by a man and a woman together. The most striking of these occurred early in the treatment when, at the end of an hour, the therapists left the room for a moment before terminating the hypnosis. When they returned to the room the patient had become severely nauseated and disturbed and explained that she had suddenly recalled an experience of over-hearing parental intercourse. The recall had evidently been stimulated by the absence of the two therapists. On another occasion, during the patient's induced regression to the age of five, one of the therapists whispered a remark to the other and the patient called out, "I hear Daddy and Mother whispering—they have too many secrets!"

There is a fundamental opposition between the handling of transference in earlier forms of hypnosis and hypnosis as we used it. In hypnosis, by direct suggestion the hypnotist strengthens and exploits this unconscious transference by investing himself with mysticism and an aura of the super-natural. That Freud's difficulties with cathartic hypnosis had much to do with the fact that he had not yet developed the technique of interpretation of transference can be clearly seen in the following remarks from his autobiography: "Increasing experience had also given rise to two grave doubts in my mind as to the use of hypnotism even as a means to catharsis. The first was, that even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient became disturbed . . . and one day, I had an experience which showed me in the crudest light what I had long suspected. One of my most acquiescent patients, woke up on one occasion and threw her arms around my neck." Freud is obviously speaking of negative and positive transference. Recent work of Erickson and Kubie reports the utilization of the transference relationship to achieve therapeutic results, but the transference itself is not analyzed. In the case which we report, the interpretation of the transference was, as in psychoanalysis, a vehicle by which we led the patient to insight into her neurosis.

The objection which is most frequently raised to the use of hypnosis as a psychotherapeutic tool is the statement that the ego of the patient with its resistances and defenses is not involved. In fact, it is said that while this is the very reason that one has direct access to unconscious material, it also accounts for the fact that hypnotic cures are so frequently temporary. It is believed that the hypnotic technique obliterates the dynamic activity of the ego, that whatever insight is gained is not assimilated into the ego and that therapy therefore effects no significant change in the ego. We

believe that this objection to hypnosis arises not because hypnosis in its very nature obliterates the ego, but because of the way it is used even in cathartic hypnosis. The attempt of the therapist in that method is simply to elicit the traumatic experiences under the theory that their re-living will cause their harmful effect to disappear by abreaction. No attempt is made to help the patients integrate newly gained insight into their egos. That the abdication of the ego is not a necessary condition of the hypnotic state, we believe has been thoroughly demonstrated by much recent hypnotic work. Our patient showed strong resistances, both in and out of the hypnotic sessions. At one point in the treatment, in a phase of strong negative transference and shortly before the emergence of some especially traumatic material, she was on the verge of disrupting the treatment to seek surgical relief for her complaints. Once when she was told in the hypnotic hour that she would have a dream the following night, she kept herself awake all night to prevent herself from dreaming. In the induced regression, when she was asked how babies are made, she replied "I won't tell you, even if you spank me," and indeed did not tell. On many other occasions she at first refused in hypnosis to communicate the material present in consciousness.

The types of formulation of insight that our patient made in the hypnotic state were no different from those in the pre-hypnotic interviews. In hypnosis she reacted to the revelations about herself with the same shame, chagrin and attempt at denial that she showed in the waking interviews. For many days her entire waking life was preoccupied with thoughts and ideas of the preceding hypnotic session. As already mentioned, despite the fact that she was an excellent somnambule, she did not have amnesia for hypnotic interviews.

As is to be expected in a case of anxiety hysteria, the patient's defense was basically strong repression. Presumably the conversion symptoms represented the points where repression alone was not an adequate defense. There seems to be no doubt that the hypnotic state is somehow able to break through the defense of repression probably in a way related to the phenomenon of hypnotic hypermnesia. The patient would frequently say, as though groping for a memory or an idea, "I know it's in my mind, but I just can't get it." She recalled one day, for example, that when she was five years old she had fallen off a porch and had broken her arm—an episode that she had long forgotten. She felt that there was something more but couldn't bring it into consciousness. In the next hour she continued to search for the elusive recollection that was just beyond her reach until she was almost in a frenzy of impatience. Suddenly, with climactic force, it burst on her that she had thrown herself from the porch in order to gain her father's attention and had accidentally broken her arm. She felt there was still more and was not satisfied until she had recaptured the

final link in the memory which was that she was trying to call her father away from her mother who was in childbirth in the house.

Sometimes she was very reluctant to attempt to pursue a certain topic and then we would insist that she would be able to recall it, employing the various devices of counting, searching for words, etc. We broke through the resistance then, not by interpretations of the reasons for her loss of memory, nor by attempts to reach the memory through uncovering successive layers of superimposed screen memories, but rather by asking for direct recall. That the recall was forthcoming we feel must be a function of the hypnotic state.

We think that in the hypnotic state the ego and the resistances can be temporarily suspended to gain repressed material and that then, within the hypnotic state, this material can be reintegrated into the ego. The patient's spontaneous shifting from past to present tense, which we previously described, can be viewed as a switching, first out of and then back into the current ego orientation. How it is that hypnosis enables more direct access to the unconscious and the repressed, we do not know. It may be that it is by way of the revival of past ego orientations in which the repression had not yet taken place. We speculate that an important factor permitting this revival of past ego orientations lies in the patient's partial assigning of responsibility for her feelings and verbalizations to the hypnotist. But this abdication of responsibility is a two-edged sword. It enables the repressed material to appear, but for purposes of therapy it must not be permitted to divorce the ego from the proceedings or else the assimilation into the personality of the newly gained insight will not take place. We believe that the analysis of the transference in hypnotic psychotherapy plays a particularly important role in establishing such ego-participation.

Psychiatrists in many places are seeking shortened forms of psychotherapy which will nevertheless be effective. Unfortunately these short forms most usually deal only with superficial matters and overlook many of the transference manifestations. We believe that in some types of cases this hypnoanalytic technique will enable more rapid uncovering and resolution of the deeper problems and more adequate dealing with the transference than short psychotherapy permits, but without sacrificing the advantage of brevity.

We make no sweeping claims for this method of treatment and indeed would like to stress our recognition that it can be properly evaluated only by constantly bearing in mind that we dealt with a case of hysteria. The chief mechanism in hysteria is repression and the hypnotic state seems to be peculiarly effective in counteracting that form of defense. Nevertheless, we believe that there is sufficient warrant to investigate this method in other neuroses and we believe that as a technique in the rational therapy of hysteria, it offers great promise.

THE USE OF INDUCED HYPNAGOGIC REVERIES IN THE RECOVERY OF REPRESSED AMNESIC DATA*

By LAWRENCE S. KUBIE, M.D.

New York, N. Y.

INTRODUCTION

The hypnagogic reverie might be called a dream without distortion. Its immediate instigator is the day's "unfinished business", but like the dream it derives from more remote "unfinished business" of an entire lifetime as well. The hypnagogic reverie differs from a dream in the fact that there is less elision of the remote and recent past, and far less use of symbolic representation. This would seem to be due to two facts: in the first place, since the reverie does not attempt to say as much as a dream, it does not need to depend upon condensed hieroglyphics to express multiple meanings. In the second place, when the hypnagogic reverie is artifically induced for therapeutic purposes, guilt and anxiety seem to play a less active role than in dreams with the result that the content of the reverie can come through with less disguise. Whatever the explanation, the consequence is that through the induction of states of hypnagogic reverie, significant information about the past can be made readily and directly accessible, without depending upon the interpretations which are requisite in the translation of dreams.

Farber and Fisher[2] have demonstrated that under hypnosis psychologically naive and uninstructed subjects can translate complex dream symbols without help. Erickson and Kubie[1] have shown that under hypnosis one subject can translate the cryptic automatic writing of another. Perhaps similar mysterious mechanisms make the disguises of dreams less imperative to the hypnagogic reverie than when fully asleep. It is probable that in this partial sleep, in this no-man's land between sleeping and waking, a form of dissociation occurs which makes it possible to by-pass the more obstinate resistances which block our memories in states of full conscious awareness, and which contribute to the distortion of memory traces in dreams.

It is not possible to estimate how widely applicable the hypnagogic reverie may be as a therapeutic technique, nor whether it is useful in certain types of neurotic difficulties and not in others. We cannot say as yet whether it will

* This study was made possible by a grant from the Josiah Macy, Jr. Foundation to the Department of Neurology of the College of Physicians and Surgeons of Columbia University.

The paper was presented at a meeting of the Topeka Psychoanalytic Society, February 27, 1943.

prove to be useful only when introduced in the course of formal psychoanalytic treatment, or whether it can be used by itself. We can say only that in a number of patients, in whom prolonged analysis had not succeeded in penetrating to the roots of a neurosis, the addition of this technique has proven invaluable. The patient's free associations seem to flow with extraordinary freedom and vividness, gravitating spontaneously to early scenes and experiences with intense affects, yet without the multiple distortions that occur in the dream process. In this way amnestic data have been recovered which proved to be essential to the therapeutic process.

A few earlier workers have been interested in this phenomenon. In 1909 and again in 1911 Silberer[8] reported observations which are tangential to this problem. Sidis[7] in this country was more directly interested in the therapeutic use of this procedure. He induced an hypnoidal state by monotonous reading, singing, and metronome beats, and then asked the subject to "tell what came into his mind . . . during the reading or immediately after" (page 15). The material that Sidis secured was of considerable interest and had he pursued these observations further and correlated them with the early work of Breuer and Freud and with the developing body of psychoanalytic theory and technique, he would undoubtedly have exercised a profound influence on the development of psychotherapeutic techniques in general.

Two recent communications have described a simple physiological method for the induction of hypnagogic states (Kubie and Margolin[4, 5]). In this method the subject's own breath sounds are picked up by a contact microphone placed against the neck, amplified, and brought back to the subject through earphones. In most individuals the sound and rhythm of one's own breathing used as a monotonous fixating stimulus has a powerful hypnagogic influence. Difficulties arise occasionally through the occurrence of swallowing noises, coughing, snoring, and the voice sounds themselves, which, because of the amplification, disturb the dozing subject. For this reason a modification of the apparatus is now being developed, in which an artificial breath sound is used at a rhythm timed with the subject's breathing. This will be reported at a later date.

Various sedative medications have also been employed, both with and without the breath sound stimulus. Certain of the barbiturates alone, the barbiturates with benzedrine, barbiturates and bromides, and other quite different medications are under investigation. A detailed report of these studies must wait upon the accumulation of further data.

The hypnagogic reverie has also been induced simply by suggesting total muscular relaxation, much as may be used in the introductory phases of a hypnotic seance, and similar to the procedures recommended by Jacobson[3]. However, the purpose of this report is not to describe technical details of the

procedure, but to illustrate from the data of one patient the type of material which can be obtained.

CLINICAL HISTORY

A man in his early forties had been in analysis for a few months in a distant city, when circumstances suddenly forced him to move to New York where, after a short interruption, he continued his analysis with me. He worked at it faithfully and doggedly, but with almost no free associations, no freedom of affect, and few affectively charged memories. In a year and a half of this he had made many secondary symptomatic gains but achieved no deep insight. Then the war intervened to take him to distant regions where there was no possibility of carrying his analytical work further. After an interruption of two years the patient suddenly reappeared in my office in a state of intense inner turmoil and unhappiness. He had taken a leave of absence of less than three weeks in order to attempt to gain some relief. The hypnotic technique described was proposed. The patient was fully aware of the hazardous and uncertain nature of such an undertaking. He was therefore quite ready to cooperate in an attack which both of us regarded as an experiment. In the subsequent two weeks the patient had seventeen sessions. On several occasions he had two sessions in one day, separated by a few hours. Of these seventeen sessions, five were prolonged periods of induced hypnagogic reverie, each lasting from two to four hours. Special time for these was set aside over week-ends, or in the evening. Intervening sessions were of approximately the usual length. The material from these prolonged hypnagogic states will be presented as fully as space permits.

The patient was a young man of exceptional endowments. He had great native intelligence, good education, a privileged position in the community, wealth, physical health, and an attractive appearance. Both parents had been cultured, and socially responsible people of distinction. They had been devoted to each other and to their three children, and had used more than ordinary imagination and feeling in dealing with their children's problems. Nevertheless the patient always felt that he was a fifth wheel to the family wagon, that his father was close to his younger sister and his mother to his older brother, the four of them seeming to him to form an intimate circle from which he was excluded. He had gone through school and college feeling like an unknown, friendless waif. He had pursued a vigorous and not unsuccessful career, yet he felt about it as though it were nothing but a pallid facsimile of his father's life. He had been married twice, but had been unable to accept the rivalry of his own children or of his step-children, with the consequence that he had been driven out of both marriages and into hopeless, compulsive promiscuity. Indeed, these

transitory relations with women were his only warming intimacies. The pain which these paradoxes and discrepancies cost him was what brought him to analysis.

In every relationship with a woman he was always compelled at first to play the role of the gallant knight saving the lady in distress, only to have the lady in distress turn out to be more boy than girl, a rival rather than a mistress, wholly reluctant to assume the mothering role towards him which he constantly sought.

The acute emotional flurry which occasioned his sudden return to me had been precipitated by a break with just such a woman, which happened to coincide with the sudden collapse of the work to which he had devoted two years of complete absorption. This collapse was occasioned by forces entirely beyond his or anyone else's control, but he had to suffer the added pain of seeing the whole project taken out of his hands and placed in the hands of those who would steer it unwisely and less competently than he.

Although he had been called upon at once to undertake an important new task, he felt unable to launch himself in it. He felt that he could not work and could not stay alone or be with people. He felt physically small, like a shrinking child. He was blue and disheartened. Not ordinarily given to symptomatic anxiety, he found himself restless, jittery and sleepless. His usual imperturbability was broken, and tears were constantly close to the surface. He felt, as he said, "shot" as he had never felt before. It was in this state that we undertook the treatment to be reported.

TREATMENT

The first session was a psychoanalytic hour of the usual type in which the patient reviewed the events leading up to his immediate distress, and described his current symptoms and the ever present sense that rejection was waiting for him.

(1) *First Session of Hypnagogic Reverie*

The session began at nine in the evening. He reviewed a few of the events of the preceding twenty-four hours, emphasizing particularly the panic that assailed him at the thought of spending the coming holidays alone. Then he was asked to remain silent, listening to his own amplified breath sounds, while focusing his gaze on a small white ring in the center of a large field of grey cloth. He was asked to count his breath sounds silently to himself, "one two, one two" or "in out, in out" (cf. Kubie and Margolin[4]). After ten minutes he was asked, "What has been going on?", and reported that he was concerned chiefly with the mechanics of the apparatus, with ruminations about his tendency to smoke too much, and with his deep conviction that there was something the matter with him.

Again he was asked to be silent, to listen to his breathing as before, and to use his own final question, "What is the matter with me?" as the starting point for his thoughts. I told him I might break in on his silence at any time to ask him what was going on, but that if anything occurred to him that he wanted to communicate to me he should signal to me.

Ten minutes later he signalled and began at once to describe vivid images of himself as a child. Not only was such vivid recall quite absent from his usual associations, but he was able to add certain new items. One was of riding his pony, of jumping it, and falling off, climbing on, jumping it, and again falling off, of doing this over and over although deeply terrified all the while. He was between seven and nine years old when he had this pony. Another memory from the same age period was of persistent nose-bleeds. This was linked to a secret fear of all the combative sports in which he took part and led to a memory of wondering whether he was really his parents' child, and to the recovery of a deeply buried rationalization of why he thought that they loved the other two children more than they loved him. "I never had any children's diseases—or did they just not care, and so pretended that I didn't have them?"

This set off another long chain of vivid recollections and images, which will be summarized here as briefly as possible:

It began with mention of his brother's closely-knit, agile, skillful body, in sharp contrast to what he felt to have been his own ungainly size, his fear of boxing, the granulated eye-lids he would develop in swimming, his utter terror of diving and inability to dive until he was nearly thirty, his fall from a dam at the age of ten, his father wading in to pull him out, his frantic terror of being clamped down and of having his face smothered under something and of being unable to move his arms, of restricted motion of any kind, the terror he felt at having to crawl under a car to repair anything or to fix tire chains or of putting his head under water, acutely vivid memories of how he felt in the swimming lessons, of squeezing his eyes tight shut and paddling frantically to the edge of the pool, of being terrified to open his eyes until all the water was out. Then came an old, old idea, "it was awful to lose your arms because then you couldn't put your arms around anyone." It was more important to put your arms around someone than vice-versa. The major bodily injury of his life had been the break which had kept his arm in a cast for months.

This led to a new memory: a bakery cart, the cupcakes from the baker, a secret rendezvous with the baker's cart behind the barn so that the grown-ups wouldn't see. This brought him up against a surprising amnesic gap. He knew that an automobile had been garaged in that barn from the earliest years in which cars were privately owned in this country. He knew that he played in and around that barn-garage from his own

earliest years. Yet he had no memory of having seen a car there until years later, nor could he call up an image of any of the horses or carriages in the old barn, nor of the old coachman and his son who was older than the patient.—At this point came an image of lying with his face to the ground, among some trees twenty feet from the garage, with the coachman's boy on top of him, his pants down—of being caught there by the governess, and of her promise that she wouldn't tell if he didn't do it again. . . . . .

At this point the stream ran dry, and he was asked to be silent and to listen quietly to his own amplified breath sounds. About ten minutes later he signalled, and described what he called "odds and ends of ideas". Actually they filled in many details of what had been amnesic a few minutes earlier. There were images of the ground floor in the barn and of the horses themselves, of the end that was reserved for cars when cars first were brought in, of the turnaround back of the stable where there was a tree, marking the place where they met the bakery wagon, of something special about that tree linking it to the coachman's boy whose name he never had been able to recall. There was the business associate whose name he had the embarrassing habit of forgetting and which he now realized was almost identical with the name of this boy. Something was going on between his brother and the coachman's boy. Then came the memory that masturbation began at that time, behind that tree and taught by the coachman's son and by his own older brother. Then he recalled that he had told their tutor what his older brother had taught him, again extracting a promise that the tutor would not tell. He remembered wanting to have both a very large penis and large breasts. He had always taken it for granted that he would have breasts, and he hoped that they would be large. The memory of always telling everything frankly was linked to a feeling that in being frank and open he went too far and got caught, whereas his brother was "cagey" and knew when to stop talking so that he wouldn't get caught.

Then came another memory of a certain kind of naive remark that he would make, spoken of in the family as a "Tommian remark" (Tommy was not his name but is used for this purpose here). A significant example was that of telling the others that when he brushed his finger-nails it made the end of his tongue twitch. He was teased and ridiculed for this; but suddenly he recalled that at a much earlier age he had bitten his nails. To this he added one new bit of historical data: he spoke disparagingly of his unusual ability to think in concrete images as something which was of no consequence at all and of a lifelong conviction that only theoretical abstractions "take brains" and are adult. This led him to an image of his mother reading philosophy aloud to his father, brother and sister, as he sat by, lost in hopeless uncomprehending admiration. He linked this with his first use of a pipe, and his compulsive, excessive pipe smoking.

Against this early ridicule he then set the image of the first occasion on which his father had shown confidence in him. He was in college: his father was very sick, and was dissatisfied with his physician, and wanted to change doctors. He called the patient home and entrusted the arranging of the change to the patient rather than to his older brother or his mother.

After an interval of floundering images came a memory of his mother showing confidence in him. He was nearly twenty. She asked him to help her balance her account. He did this scornfully, making the corrections in bold emphatic figures to indicate his scorn. Then back again to an early memory of Christmas morning, of coming down for their stockings, of finding the stockings filled with coal and kindling but with a five dollar gold piece in the toe. He could never remember getting his. He was too mad and hurt. This was in no way relieved by the real stocking which came afterward.

Three hours after the session was begun it was interrupted and the patient went home. . . .

(2) *Second Hypnagogic Session*

The next session involving the use of hypnagogic reveries occurred on the following day in the early afternoon. It began with fifteen minutes of silent attention to his amplified breath sounds. At the end of this time he signalled and expressed a desire to describe a "whole series of things that have been going through my mind".

He began by describing his sense of isolation from other boys, his feeling of his inability to do anything as well as they did, and his tendency to console himself and to compensate for this and in a sense to control others through sex. This led to his sense of always overreaching himself, of having gone to college too young, because he had made up three years of preparatory work in a year and a half. He was too young for the S.A.T.C. He was too young when he took over his job. He feels too young now as he faces the new assignment that awaits him. His only compensation is to get a woman under his thumb sexually, so that he can let out his anger, and still save himself from the danger of being alone and from the danger of losing his only potency through masturbation. At this point the thought of waste came to mind and his flow of ideas was blocked. He was again asked to be quiet, to focus his attention on his breath sounds, and to use the concept of waste as the starting point of his reverie.

Ten minutes later he signalled. First there was considerable rumination on the topic of waste and his own general sense of failure. Then he lapsed into silence again, shut his eyes and drifted off for nearly fifteen minutes. Then he signalled again and took up the theme of ridicule and of its relationship to his feeling about the "concrete" and the "abstract", how you

couldn't make yourself ridiculous with concrete things whereas it was with regard to "adult abstract things" that he made the old "Tommian remarks", how he was more afraid of ridicule than of anything else in life, and of how the sense of having been ridiculous made him ashamed when at the age of nine he had fallen off a high cross-bar breaking his arm, fracturing his ribs, and dislocating his hip, thus laying himself up for several months. He had been "showing off" to some older boys and girls who were there. It was a high flight followed by a ridiculous fall. It was this that broke his spirit at that time, and not the pain. Then he went on into details of how this feeling had stayed with him, and how it had influenced his relationship to his school-mates and to his older brother and to all friends.

This was new material and, as he remembered it drowsily, he added further detailed images from his puberty years and early adolescence. Their recital took the rest of the afternoon.

(3) Third Hypnagogic Session

The next afternoon he came for another long session. He went through a short recital of the events of the intervening hours, picking up further ruminations on the general topic of ridicule, his impulse to ridicule others, his incessant sense of being a child vulnerable to the ridicule of grown-ups, and his need to use a woman as someone behind whose skirts he must hide himself or in whose train he might be swept into the company of the mighty.

Then he drifted on into a period of silence, listening quietly to his own breathing, and after about ten minutes, stirred and gave a signal that he wished to communicate something.

It was between the ages of four and five. His father was away. At such times the children in turn were allowed to sleep with their mother, or else just to come in to her bed in the morning. He was sleeping or lying there, cuddling close to her body, feeling how warm and lovely this was. Then suddenly he was being pushed away and was being told that he "was too old for this". He never in his life got into his mother's bed again. He felt guilty, and angry at himself for not having foreseen that this would lose him this warm and glowing opportunity. Once again he had been too "frank and open and direct" instead of sneaking up on it as his brother would have done. Then he thought of a rejected gift that he had bought for a governess, and of feeling ridiculed for wanting to help his teacher by writing sample manuscript letters for her.

After fifteen minutes he lapsed into silence, again focusing on his amplified breath sounds, with his eyes on the white ring—then returned to the critical scene with his mother.

He was lying on his left side. She was lying on her left side. He snuggled up to her that way—"that's the way I always want to go to sleep with

a woman even now". The persistent power of the rebuff was so great that he has never held one of his own children in his lap in an affectionate manner, or put his arms around one of them, not with his own nor with any other child. He'd like to do this. (At this point he cried, which was striking in view of the fact that he had never been able to show feelings in the analysis, nor a moment's tenderness or gentleness to one of his own children or to his step-children.)

Suddenly he remembered a later contrasting episode. He was standing next to his mother as the family were playing a game together. Suddenly he found himself with his hand around her waist or shoulder. He felt an intense inner amazement and surprise. He expected momentarily to be pushed away. The surprise was so great that he could not take his mind off of her to think of the game. He kept coming back to her to put his arm around her again. She did not push him away. Then came the thought of his mother and father always very "sweet and affectionate and demonstrative to each other", and of his mother seeming to him to be so towards his brother, and his father towards his sister, but of no one turning towards him.

Then he went back again to the original episode in bed with his mother. He was sure of its sexual nature. It was linked in time with the episode with the coachman's boy. He may have had an erection. He had a vivid kinaesthetic and tactile memory of the sensation all along his body of the area of contact from his chest to his knees as he lay along his mother's lower back, buttocks and thighs.

Then he thought of his mother's words, "you are too old for that", and said he understood for the first time his lifelong and literal fear of growing old. He could remember his belief that parents had intercourse once for each child, which meant that with a family of three or four children intercourse occurred three or four times in a lifetime. Therefore sex and "snuggling" was no part of being an adult and therefore one doesn't want to grow up at all because this meant to lose all hope of what one most wants. Snuggling is a necessary sensation. . . .

After another silence he signalled again, and said "This explains the fascination of breasts. Legs never count, only breasts. . . As you grow up you come to believe that you should never express any feelings", because whenever he is tired or strained the first thing he wants to do is to cry. He is torn between love of and hate of his mother, between yearning for her and scorn of her. The only feeling he could not hide from himself was rage. If he could only once begin to talk about his feelings he'd "shoot the works". Then came a sudden flood of convincing bits of evidence that his associates in his many activities had great fondness for him; something he had never been able to admit.

Then he suddenly commented "It's funny to have it all bounce up to the present so quickly. It's a funny feeling that the older you get the less possible it gets to express any feelings, and finally even to feel a feeling". "Growing up means getting cold and hard and stony, out of terror lest my feelings would run away with me and govern everything. I'm impatient. I wonder about the application of all of this to the problems which face me"..

Suddenly he thought of the fact that every woman he has chosen has always been a woman who is running away from him. Then he said in a rather awed voice, "If mother would ever turn over towards you, then you're as good as father". "To be alone means to be rejected, and what's more to be rejected by mother". "To snuggle up to a woman and go to sleep is more important than intercourse. But mother must be there to let me snuggle"....

These sessions were followed by a series of ordinary psychoanalytic sessions, interspersed with two shorter sessions of hypnagogic states. These evoked no new material but reworked the data that had already been covered, relating them in many different ways to the problems which had beset the patient all through his life. He became increasingly eager to return to his job and actually cut short his holiday to do so. He saw the woman who had been concerned in the precipitation of the acute illness and had a feeling, as he put it, that he "could take her or leave her" without its being a catastrophe either way, and that he "saw her as a human being" for the first time. He felt physically as large as anyone in his office, instead of feeling physically "overawed and little", in a world of towering rooms and furnishings and giants. His feeling of his own body seemed suddenly to mature (it should be borne in mind that this was a man of more than average size, broad shouldered, and athletic).

His own subjective impression was that the long hypnagogic reveries seemed to bring up not only the new factual data, but all of the attendant sensations and affects which linked them dynamically with his life.

It is unfortunate that the written records of these events can give so little of the breath of life which infused the memories themselves. For this reason, however, it is impossible adequately to convey the contrast between the barren sterile intellectuality of the preceding years of analysis, and the free affectivity of the memories recaptured and revivified in these hypnagogic reveries.

In a peaceful and optimistic state he returned to work. Eight months later he reported that he has been steadier, more cheerful, and more independent than ever before in his life.

With a patient who had been in analysis for a long time, it is impossible to say that the months of analytical work did not in some measure color, or

provide material for the data obtained subsequently in hypnagogic reveries. We can say only that in this particular patient the material had remained inaccessible until this technique was added. The degree to which similar material is accessible by this technique in patients who have not been in analysis, will have to be demonstrated in later communications. At this point we can say only that we have had enough experience with the method with patients who have not been analyzed to feel that the same basic forces are at work in both groups, and that the recovery of buried amnestic data is greatly facilitated by the use of hypnagogic reveries irrespective of analysis.

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USE OF THE RORSCHACH TEST IN THE PREDICTION OF HYPNOTIZABILITY

By MARGARET BRENMAN and SUZANNE REICHARD

I. INTRODUCTION

Investigators of hypnotic phenomena have always felt the need for an objective method by means of which the hypnotizability of the individual subject might be reliably forecast. Most workers have found little or no value in the attempts to correlate hypnotizability with naively formulated "personality traits" on a questionnaire; instead, they have preferred to rely, for prediction, on a set of intuitive hunches, usually impossible to communicate. Most agree that their final test, however, is simply to try to hypnotize the individual in question. Where group hypnosis is unfeasible, this trial-and-error process wastes much time and energy in the selection of subjects for research. In discussing a therapeutic problem, the worker in hypnosis must condition his recommendation of any variety of hypnotherapy on the outcome of his trial attempts with the patient.

In the course of routine application of the Rorschach Inkblot Test to a variety of clinical problems, it seemed to us that a great deal of this waste motion might be avoided if we explored the potentialities of this test for predicting hypnotizability. This application of the test seemed to us to promise more than earlier attempts to find the significant "personality traits" in good and poor subjects, because clinical experience had shown the Rorschach Test to have inestimably greater predictive value on other grounds.

II. PROCEDURE

The Rorschach Test was administered to 33 hypnotic subjects, 22 of whom were psychiatric patients and 11 of whom were nurses and attendants. Of this group, two patients and four volunteers proved to be "somnambules"; each showed a total amnesia after the first hypnotic session and some were amenable to hypnotic regression and to negative and positive hallucinations. These six, then, constituted the "good" group. In the group of 33, two subjects, both patients, showed no response to prolonged efforts to hypnotize them. In the six poorest of the remaining group, prolonged efforts resulted only in the minimal hypnotic phenomena which usually define the "light trance." For purposes of statistical evaluation these eight subjects, two employees and six patients, together constituted our "poor" group. We compared the Rorschach data from the two groups thus formed, in order to discover whether there were statistically

significant differences* between the good and poor subjects in any of the Rorschach factors.

For the sake of clarity in presentation, and in order to avoid overburdening the text with Rorschach technicalities, we shall present our results in clinical terms and take for granted the usually accepted relationship between certain clinical findings and the corresponding determinants in the Rorschach.† Those who are interested in the technical details of the research will find them discussed in the footnotes. A detailed comparison of the scores of the good and poor hypnotic subjects may be seen in Table I, which shows the means of the various Rorschach factors in both groups.

1. The most clear-cut of our results is the fact that the good hypnotic subject shows "free-floating anxiety" more frequently than does the poor

* The significance of differences between the means of these data was tested by "Student's" t-test.

† In order that the description and discussion of results may be intelligible to the reader unfamiliar with the Rorschach Inkblot Test and the factors scored in it, we present the following brief discussion of those factors relevant to this investigation. In this test the subject is presented successively with ten cards with inkblots on them in black and white or in color, and is asked "What might this be?" The subject's response may be determined by a great number of different properties of the inkblot. For example, an individual may designate a red area of the blot as "blood" solely because of the color. Such a response is a pure color response (C) and usually indicates a tendency toward "uncontrolled impulsiveness". When the subject's response is determined mainly by the color but partly by the shape or form of the blot (CF) this indicates a strong, responsive, but only partially controlled affectivity. An example of this is: "Looks like a gladiolus because it is the color of a gladiolus and it's sort of shaped like one, too." When there exist simultaneously a well-controlled, adaptive affectivity, well harmonized with the perception of form, the subject's response to the blot is determined mainly by the shape of the area but partly by the color as well (FC), for example: "This is a beautiful pink butterfly."

When the subject's responses are determined wholly or partly by the shadowy or light-dark relationships in the blot (chiaroscuro) it is considered that the response reflects the presence and the degree of control of anxiety. Here, as with color, the response may be determined solely by the chiaroscuro (Ch) as in the response "Clouds", a pure "Ch" response reflecting uncontrolled anxiety; on the other hand "topographical map" reflects a partial control of the anxiety (ChF) because some attention is given to the form; and "furry hide of an animal" indicates a more complete control (FCh).

The responses which describe human beings in actual movement (M) are reflections of the native endowment and the intensity of the ideational activity of the subject. The ratio between the total number of such movement responses and the weighted total of the color responses is termed the "experience balance."

The term "coarctated" is used to describe an experience balance in which there is very little color or movement, but mainly pure form responses. Such a record is given by rigid, constricted personalities. Further detailed discussion of the Rorschach Test may be found in (2) and (3).

hypnotic subject. Not one of the poor subjects gave any responses indicative of this factor.*

2. The second finding is statistically less reliable than the first and is therefore to be considered only as a trend. It appears that what Rorschach regarded as labile affectivity may be positively related to hypnotizability.† Moreover those subjects who show a preponderance of the indicators of "extratensiveness" over indicators of introversive trends in their make-up are more prone to be readily hypnotizable. We use the term "extratensiveness" rather than "extraversion" here because the affectivity is not necessarily outgoing and well-adjusted but may be egocentric and labile.

TABLE I

RORSCHACH FACTORS IN HYPNOTIC SUBJECTS*

Means

	No.	R	W	D	Dr	S	s	AdS	M	FC	F/C	CF	C/F	C	FCh	ChF	Ch	M:ΣC
Very good subjects....	6	36	8.7	19.5	3.5	0.2	0.5	0.7	2.1	1.7	0.2	1.5	0.5	1	1	0.8	1	2.1:4.4
Poor subjects.	8	23.5	6.8	12.8	2.1	0.5	0	0.5	2.8	1.3	0	0.5	0.5	0.4	0.5	1	0	2.8:2.2

Percentages

	W	D	Dr	S	s	M	A%	H%	Hd%
Very good subjects.....	27.7	55.2	8.5	0.3	1	6.5	43	20	10.7
Poor subjects.....	35.1	51.3	6.3	1.6	0	8.9	50	16	5.25

* R, number of responses; W, whole responses; D, normal detail responses; Dr, rare detail responses; S, large space responses; s, small space responses; AdS, additional space responses; M, human movement; FC, form-color; F/C, form plus arbitrary color; CF, color-form; C/F, arbitrary color plus form; C, pure color; FCh, form-chiaroscuro; ChF, chiaroscuro-form; Ch, chiaroscuro; M:ΣC, movement to sum of color; A, animal responses; H, human responses; Hd, human detail responses.

3. In no other factor was there any trend which could be used to distinguish reliably between the two groups. We found no evidence for the existence of a relationship between the "whole-detail" ratio‡ and hypnotizability, and thus were unable to confirm the findings of Sarbin and Madow.[4]

* The difference was quite significant; "t" was 4.52 giving a probability of less than one per cent that such a difference could occur by chance.

† The weighted sum of all the color responses, as well as that of CF + C, yielded differences which showed tentative reliability. The difference found between these scores in good and poor hypnotic subjects may occur by chance in less than five cases out of 100.

‡ W/D ratio. When the blots are responded to as wholes, the response is scored "W"; when the response is to details, it is scored "D".

In concluding this section, we shall present a comparison of the two best and the two poorest subjects in order, first, to summarize our results in terms not solely of statistical frequencies but also of the individual test protocols; and secondly, to suggest areas in which further investigation might prove fruitful.

Our two best subjects were conspicuous in that they showed the most marked predominance in the good group of "extratensive" over "introversive" tendencies and the most indication of "labile affectivity." Evidences of negativism were absent. Both subjects had indications of anxiety, but did not exceed the other members of the good group in this respect. Both showed average productivity, in the sense that they both gave an average number of responses to the test, and both gave some responses to "rare details" in the cards. An unusually high percentage of the responses of one of the subjects were to the card as a "whole," indicating good organizing and survey ability; while the other subject gave an unusually low percentage of such responses.*

On the other hand, the two poorest subjects exhibited a complete lack of any indicators of anxiety, differing in this respect not only from the very good subjects but also from the other poor subjects, of whom all except one gave some indications of partially controlled anxiety. Both of them showed a fairly balanced relationship between "extratensive" and "introversive" trends and failed to show any labile affectivity; one was a very inhibited compulsive neurotic subject, but the other showed some pure color responses on the test, indicating the possible presence of epileptic equivalents. Both subjects gave indications of negativism. In both, the number of responses also was somewhat below average, and rare detail responses were completely lacking.

These comparisons suggest that the number of responses, the rare detail responses, and especially the indicators of negativism, are the most promising areas for further investigation.

IV. DISCUSSION

Although there have been several attempts to establish relationships between "personality traits" and hypnotizability to the end of making valid predictions, most of these investigations have employed stereotyped questionnaires and have thus been unable to discover any personality factors which appear to be regularly associated with a good response to hypnosis. A detailed discussion of the results of such earlier studies as they relate to this investigation would take us beyond the scope of a preliminary presentation. However, it is of direct theoretical interest to view our results against the background of Rorschach's statement of the manner

* In the latter, this was an expression of the strong depressive trend present.

in which "suggestibility" is reflected in the Inkblot test. This is of particular importance in the context of the existing controversy regarding the relationship between everyday "suggestion" and the phenomena of hypnosis. Rorschach[3] (p. 100) says: "Affective suggestibility is represented in this test by the CF responses; M, FC and C answers may or may not be present; in any case there must be a predominance of CF's, either absolutely or relatively. . . . The greater the number of M's in the experience type formula, the less suggestible is the subject." In other words, according to Rorschach, strong introversive trends seem to be unfavorable to hypnosis, while affective suggestibility or, in broader terms, labile affectivity is favorable.

Although our results suggest that "egocentric affective responsiveness" may be involved, it would seem that the factor of "free floating anxiety" is of even greater importance in hypnotizability. Thus, if one assumes with Rorschach that responses purely to color or even to a combination of color and form are characteristic of ordinarily "suggestible" persons, it would appear that there does not necessarily exist a one-to-one relationship between hypnotizability and everyday suggestibility. That is to say, "suggestibility" alone, as Rorschach understood it, appears insufficient to make the individual a good hypnotic subject. We should like to emphasize, however, that we recognize the fact that every personality characteristic may be represented in several different ways in the Rorschach responses. Thus, there may be factors fundamentally "equivalent" to those we have found in the sense that in combination they too might be reliably linked with hypnotizability.

Further investigation with a greater number of subjects may show more specifically which factors may negate the influence of those factors which appear to be positively related to hypnotizability. For example, clinical experience has shown that some individuals who manifest "free floating anxiety" as well as relatively labile affectivity, both favorable "signs," may still be relatively poor subjects. There are some indications that a kind of negativism, indicated by responses to the areas of white space, independent of the other two predisposing factors, may interfere with all efforts to induce hypnosis. A systematic investigation of these problems holds the promise of establishing a practical tool for predicting hypnotizability and of suggesting some of the dynamics involved in hypnotizability.

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HYPNOTHERAPY FOR MENTAL ILLNESS IN THE AGED

Case Report of Hysterical Psychosis in a 71-year-old Woman

By MARGARET BRENMAN, Ph.D., and ROBERT P. KNIGHT, M.D.

Certain departures from the traditional technique of hypnotherapy have been presented in a preceding paper.[4] We shall here discuss a variation of the technique described as it was employed in the treatment of an hysterical psychosis in a 71-year-old woman.

We report this case because we were unable to find in the literature another case where, in treating so old a person, hypnosis was used not simply for the suppression of symptoms but for the development of insight into their meaning. We shall describe the evolution of the treatment, which began with the modest aim of alleviating by direct suggestion the patient's most prominent symptoms. This procedure was gradually replaced by one which elicited from the patient a progressive translation of the symbolic significance of her bizarre and violent symptoms, until after 70 hours of treatment she was symptom-free and well adjusted to her environment, and felt that she understood the "meaning" of her illness.*

PRESENTING ILLNESS

Six months after her husband's death which occurred 1 year before her admission the patient had begun to complain of acute stomach distress and resulting insomnia. Although she had been complaining for forty years of "gas on the stomach", which had begun during her sole pregnancy, it had never before so intensely disturbed her. A thorough clinical examination failed to reveal sufficient organic basis for her difficulties. As she became increasingly distressed, she was persuaded to accompany her brother to his ranch. Here she became markedly depressed, complained incessantly, and began to avoid people. Gradually she began to talk of burning sensations throughout her body, of worms crawling in her extremities, and of the impending loss of her eyesight, her hearing, and her mind. She then developed a tremor of her lower jaw which soon developed into a series of generalized bizarre "shaking spells". During these, she manifested all kinds of strange and violent contortions, to be described, which she declared she could not control and explained as the result of the "gathering of that gas inside of me"; these contortions would sometimes subside after she was successful in belching. When the patient began to express

* At the present writing, the patient has been well, except for occasional minor complaints of "gas", for a period of six months.

suicidal ideas and fears that she might hurt someone, her brother became alarmed and brought her to the Sanitarium.

HISTORICAL SKETCH

According to information obtained from her brother, the patient was one of 13 children; the family was closely knit, and she had made relatively few friends but had attracted many beaus in her girlhood. She had given piano lessons and taught school, and at 28 had married a quiet, withdrawn man who strongly disliked the city and so had chosen a profession which necessitated his living in the country. Because the patient could not tolerate country life they lived separately during much of their married life, although they saw each other frequently. Whenever her husband was ill the patient always went to take care of him.

When she was about 50, the patient found that he had been surreptitiously giving money to a widow. Impulsively, she went to see a lawyer for advice on a divorce action. Her daughter believes that her father never forgave the patient this impulse, even though she abandoned it almost immediately; the daughter believes also that there were no real grounds for so drastic an action and maintains that although the widow had pursued her father, the relationship had never really developed. During the last three years of her husband's life, the patient lived with him on a farm, ministering to his needs.

REACTIONS TO HOSPITAL CARE

When the patient was brought to the Sanitarium she kept up an incessant stream of plaintive remarks which detailed what appeared to be an almost delusional view of her symptoms. She repeated frequently that she needed a "stomach specialist" and resisted with violent emotional outbursts any attempt to discover existing psychological difficulties. She apparently felt she had been tricked into coming to a place where she would be "disposed of" and "used for research, but not treated". She seemed inaccessible, and her behavior was clinically psychotic.

During her first two weeks at the hospital, the bizarre character of her behavior became more marked. The following account was written by her admitting physician:

> "She spends the major part of her time in her room where she either sits quietly with an occasional rhythmic tremor of one leg or she paces back and forth hurriedly in her stocking feet because she likes the feel of the cold floor. She writes lengthy letters to her sisters and daughter in which she describes her subjective reactions from moment to moment throughout the day as well as observations about other patients. Her bizarre movements usually increase markedly in the presence of the physician, nurses or other patients. The rhythmic tremors usually start in one extremity and

increase rapidly in amplitude until all the extremities are involved; sometimes if the examiner restrains one extremity at the start, the rhythmic movement will appear elsewhere. During the physical examination the patient began to rub her abdomen rhythmically to demonstrate the presence of "the gas" and soon her whole body was involved in rhythmic convulsive-like movements. She shakes her wrists vigorously, stands with her hands on the bedstead, and then hops up and down with both feet while at other times she hops, almost leaps, about the room for a few moments while continuing to talk about herself. After these strenuous exertions she does not appear unduly fatigued. She frequently demonstrates the various movements to the examiner, while discussing them, in addition to displaying those which she says she can't control. At times she emits resounding belches with seemingly great effort, pressing her abdomen during the process. She eats well and complains of still being hungry although she has hesitated to ask for re-orders. Several times she has slept with only a thin sheet over her during cold nights because she has felt so warm. While on walks she tries to leave her coat open. She objected strenuously to sedative packs and became almost resistive, bruising a toe as a result of her contortions while in a pack one day."

When the patient was discussed by the staff, it was unanimously felt that she presented not only an extremely difficult diagnostic problem but also a serious problem in institutional management. Treatment recommendations were exceedingly difficult to make, by reason not only of the atypicality of the syndrome but also of the complete inaccessibility of this patient. Because of the hysterical features in the clinical picture, the suggestion was given that an attempt be made to hypnotize the patient; it was hoped that additional anamnestic material might thus be elicited, and that a temporary alleviation of her most disturbing symptoms might be effected by direct suggestion. It was concluded that eventually electroshock treatment would probably be necessary. The prognosis was decidedly guarded.

COURSE OF HYPNOTHERAPY

The patient agreed, though reluctantly, to come for a trial session. She walked hesitantly into the room, glanced dourly at the therapist, and immediately fixed her hands on the desk, hopping violently on both feet, her teeth set and lips drawn back in a frenzy of exertion. When she momentarily ceased her hopping, she began to pat the desk-top with her hands in such a way that it appeared as though her hands were hopping over the desk. Suddenly she gave this up, left the desk, and strode with great energy back and forth, complaining loudly of the heat and smallness of the room and the absurdity of the type of care provided for her. She turned abruptly each time and finally stopped short, only to begin hopping anew, first on one foot and then on the other. Then she began to flail her left arm and to fan the air with her right hand at an incredibly rapid tempo. She finally sat down, on request, and when she was asked if it were pos-

sible for her to control these acts, she replied by holding her arms quietly on the chair; at this moment her right leg fairly leaped into the air and then began to pound the floor like a piston.

She tried to explain that her strange behavior fell roughly into two general categories: first, the kind of performance she was displaying at that moment, which she said was entirely beyond conscious control; and secondly, a type of "monkey-shines" which she thought she could possibly control, but felt she "had to do". To illustrate this second type of behavior she described a ritual which she had gone through hundreds of times at her brother's ranch. She would hold a handkerchief aloft, let it drop, and then watch to see whether "it stood up straight in a point" or whether "it just fell flat". Another example consisted of her getting down on all fours in the train compartment and "rearing around like a dog", much to her brother's consternation.

The results of the first few attempts to hypnotize the patient were extremely discouraging. She made no attempt to conceal her deep scorn for the procedure and, at first, would not cooperate even to the extent of sitting down for more than two consecutive minutes. She would suddenly jump up, shouting, "I can't concentrate", and commence to hop and whirl around the room. Typical of her derisive remarks was, "It would be better to take an enema than to come down here." When such remarks were countered with a friendly and slightly cajoling attitude, she would seem temporarily ashamed and make an obvious effort to cooperate with the barest mechanics necessary for the induction of hypnosis.

Gradually the patient's attitude changed from frank resistance to a reluctant, perfunctory acquiescence to the request that she sit down or that she relax her body. This made possible a light hypnosis in which the direct suggestions were made that she sleep better, that her violent contortions subside, and that her acute stomach distress be relieved. It soon became apparent that these suggestions were taking effect, inasmuch as her hyperkinetic movements had markedly decreased.* After six hypnotic sessions —over a period of two weeks—the patient grudgingly admitted that she was improved, but she maintained firmly that this was to be attributed to excessive sedation and that now we were turning her into a "dope fiend"; she thought she would ask to have the treatments discontinued.

It was not until the twelfth hour that a clear-cut turning point in the treatment occurred. Hitherto very little attempt had been made to convince her of the difference between the normal and the hypnotic state; it had been her tacit assumption that she had been "going along" with the

* This subsidence of her motor symptoms was progressive and gradual during the remaining period of treatment. They were completely absent when she left the Sanitarium.

treatment because her daughter wanted her to, but that she had not been responding in any way. During this hour, however, it was apparent to the therapist that she was in a deeper state of hypnosis than ever before. Accordingly, she was told she was unable to open her eyes. She laughed, said, "Nonsense", and proceeded to try. When she found to her amazement that she could not, she smiled in some embarrassment, saying, "You really have got the best of me, haven't you?" At the conclusion of this hour, she asked if she might be scheduled for several additional appointments each week, and from this time on her attitude was eager, friendly and completely cooperative. Because of this remarkable shift in her attitude, we decided to abandon direct suggestion for a more dynamic procedure which would provide the possibility of her gaining some insight into the significance of her illness. We did not expect to elicit any dramatically illuminating material, and certainly did not hope to gain a real understanding of the symbolic significance of her symptoms. We hoped only to help her verbalize a portion of the emotional conflicts which she might regard as precipitating factors. She had hitherto obstinately refused to discuss any personal matters. The specific techniques used were generally similar* to those described in a previous report[4].

We were startled a day later when, during the hypnotic session, the patient began to talk with extraordinary freedom. She was asked in hypnosis to "go back" to the time when her insomnia first began and to speak aloud whatever occurred to her. She said:

"I hear Ed . . . going down the front steps and oh . . . it's awful, awful . . . wicked, selfish . . . I am thinking . . . of, could I have ever really thought that . . . yes, I know I did . . . I'm thinking I wish he were dead!"

She spent the remainder of the hour elaborating this theme, interrupting herself to sob bitterly over the memory of the hostility which had characterized the twenty years since she had suspected her husband of infidelity and had consulted a divorce lawyer.

During the next few hours, she continued to express with great emotion the almost irreconcilable opposites of her feeling toward her husband. She had admired and respected him, and thought of him as "a prince among men", but she had wanted him to love her in a warm and demonstrative manner, and had hated him for his coldness. Apparently he could never show any real affection, even before her impulsive trip to the lawyer.

* One practical difference lay in the fact that in this case only the author trained in hypnosis (M. B) had actual contact with the patient. The progress of the case was, however, followed in minute detail by the author trained in psychoanalysis (R. P. K.) and was supervised by him.

Throughout it was extremely difficult to assay the character of the patient's husband, but the available data suggested that he was an extremely schizoid individual who never became genuinely intimate with anyone and who, after he became impotent in his fifties, indulged in a kind of genteel Don Juanism. This took the form of helping attractive middle-aged widows who were in financial distress. The patient spoke with great bitterness of these episodes and felt during the last years of his life that she could not tolerate the "grudge" she carried toward him for rejecting her; she thought that when he died it "would be all over" and that she would be relieved of her burden of frustration and hate. She had felt, too, that if he died he would no longer be able to "carry on" with other women and that again she would be "first in his life".

Her first effort to translate her symptoms into meaningful terms came in answer to the direct question "What are you trying to express by these different acts?" She replied on two separate occasions that they were a "release" and a "satisfaction", but was still unable to say what she meant by these terms. She provided a clue, however, by following this response with a criticism of her hospital physician who had made her "speechless with rage" when he had attempted during the preliminary history taking to question her about her "sacred relationships" with her husband.

As she was discussing what she termed her "agitation", she suddenly had a vivid visual impression of her husband seated at a table, but added, almost sorrowfully, "I can't say that I see the food." Actually the patient's appetite had gradually increased since the onset of her illness, and she frequently mentioned this as a saving grace; she wrote to her daughter: "I am so *very, very* hungry; I eat up every crumb from my tray. Must be the medicine they give me." This preoccupation with food and eating, with hints of food deprivation, suggested a symbolic significance and this was confirmed in the succeeding discussion of her "nervous indigestion".

She regularly gave associations of a frankly sexual content in answering her own question, "What caused my gas?" but thought them "silly" and "irrelevant" until the consistency of their appearance brought her to the realization that she regularly linked her adolescent and adult conflicts regarding genital sexuality with her alimentary disturbances. She spontaneously offered the information that "the sex part of my marriage never nauseated me at all", but shortly thereafter described herself as having felt "trapped" into becoming pregnant, and it was during this pregnancy that her chronic gastrointestinal difficulties had begun. She had acceded to her husband's demand for a child, hoping thus to "win his favor", after he had bitterly commented that a childless wife was no better than a prostitute. The patient devoted almost ten hours to this problem and gradually gave

up what had been previously a tedious barrage of whining complaints about "this terrible gas gathering inside of me".

For a brief period following the discussion of this problem, the patient was aware of an intense sexual interest in several of the male patients. This development shocked and alarmed her; but after she had been assured that these feelings would not continue at such a pitch, she settled down to a kind of flirtatiousness which is socially acceptable in elderly ladies.

The patient now attacked the problem of translating the symbolism in what she termed her "monkeyshines". She was told in hypnosis to re-experience her feelings and thoughts in relation to the described handkerchief ritual. At first, she replied simply:

"Win or lose . . . win or lose . . I see . . . if it stands up in a peak, I win; if it falls flat, I lose."

She added then that this made no sense whatever. During the next several hours, she extended the introspections accompanying the ritual. She suddenly felt the behavior was somehow related to her husband, and finally said:

"It meant if it stood up, I could entertain a thought that we could be friends again and if it fell down flat, my hopes were in vain. But that was so foolish, because he was already dead."

When she was asked why she chose this specific act, she could not say. The technique of inducing vivid visual experiences was now introduced; the patient was told that she would see an object as though it were projected on a screen and that the image would be the object which the handkerchief symbolized. At first, she stalled ingeniously by saying that she could see an object dimly but that it was behind the screen and so was obscured. Gradually she began to see shifting outlines, the clearest of which was "the huge strong body of an elephant—his strong limbs"; this was quickly followed by the image of an "extremely beautiful woman" in a glamorous pose.

Shortly after this experience she volunteered the following:

"You know—I have been telling you that when my husband lost his desire I lost mine too—and that it didn't matter to me a bit . . . In fact it seemed to me that I didn't even miss that sacred relationship, but yesterday it suddenly flashed into my mind that for years and years I kept dreaming about having that sacred relationship with Ed . . . In my dream I would think to myself, 'At last I've done it—at last it's happened. Now we will be friends again!' Not that the sacred relationship is all there is to marriage but it seemed like if I could get him to become interested in me again that way that perhaps we could start all over again."

Directly following this statement the patient was asked whether all of this had anything to do with the handkerchief ritual. She laughed em-

barrassedly, blushed, and asked whether the handkerchief might have symbolized her husband's "organ". At the close of this hour she said, "That hour was a real satisfaction to me somehow. I don't understand why, but I feel different than when I came."

Now it appeared that this insight released a flood of associations, all of which pointed to a formulation that her grotesque bits of behavior had been a symbolic "acting out" of her deep need to undo the long estrangement from her husband by renewing their sexual relationships. Although it is not possible in the available space to detail the gradual unfolding of these, a few of the patient's conclusions will be mentioned. She recalled, for example, that directly following her husband's death she had been seized by an uncontrollable desire "to lie down on my back in bed". To explain her "rearing around like a dog", she suggested the fact that "animals have no restrictions". The patient interpreted her "hopping spells" in the following way:

> "Well, it seems if a person were happy they might be hopping up and down with joy . . . Maybe my subconscious was saying, 'Ed and I are friends again . . . isn't it wonderful . . . now we're together again, now it's all solved' . . . but that seems more like a little child would express being happy . . . Seems like when I was a little girl if something very nice were going to happen, I would hop up and down or jump all around the room."

During the final ten hours of her treatment, the patient seemed eager to make intelligible each detail of her bizarre behavior. It was as if a key to a code had been given, and she were simply applying it to the deciphering of dozens of specific messages. She stated that the repeated patting of coverlets and desks symbolized an attempt to reinstate her old way of "getting Ed ready", and that her fanning movements were an attempt to cool herself down. She said she had felt like "a dog in heat", and thus explained her terrible burning sensations.

It would appear thus that the patient's illness was a fantastic attempt to solve the long-existing problem of her relationship with her husband by a series of symbolic actions. She summarized it by saying, "Seems like what I was trying to do all along was to become friends with Ed—and it seemed that the way to become friendly was to start having relations with him again." No mention has been made of the aggressive aspects of the patient's symptoms; it seemed throughout that these were quite secondary to the erotic gratification which her symptoms provided. However, it should be pointed out that many of her symptoms had a "restitution value"—to undo her death wishes against her husband, bring him back to life, and reinstate a good relationship between them.

DISCUSSION

Even after 70 hours of intensive treatment, it was not possible to place this patient in any one of the standard diagnostic categories. On admission, and for several weeks thereafter, she was clinically psychotic. Despite her advanced age, she showed no significant senile symptoms. She exhibited some features of agitated depression and even some paranoid elements in her suspiciousness and in her delusional view of her somatic symptoms. However, these were overshadowed by the long-standing organneurosis, focussed on gastrointestinal difficulties, and by her compulsive rituals* and hyperkinetic movements. The last mentioned symptoms often gave witnesses the impression of being relatively close to conscious control, and thus were reacted to by her relatives with some irritation, as though she were consciously "faking". This reaction, so frequently elicited by hysterics, together with the remarkable recovery of memories dating back 50 and 60 years, speak for a diagnosis of hysteria. However, inasmuch as her behavior went beyond the recognized limits of a neurosis, we were led to apply the almost obsolete diagnostic term "hysterical psychosis" because it most nearly described her unusual syndrome.

The highly symbolic motor expression of her unconscious strivings raises a provocative theoretical problem. We know that in the normal individual unconscious wishes are constantly trying to "force their way through the pre-conscious system to consciousness and the command of motility"[1]; the powerful counterforces relax only at night and permit some of these impulses entrance into consciousness, but even then this freedom is limited by the fact that the impulses are heavily disguised and the "gate to motility" is closed. Freud, speaking of the action of unconscious wishes in sleep, says:

> "No matter what impulses from the usually inhibited unconscious may bustle about the stage, there is no need to interfere with them; they remain harmless, because they are not in a position to set in motion the motor apparatus which alone can produce any change in the outer world"[1].

He points out, moreover, that in two conditions this "safe" relationship of unconscious wish and available motility does not exist: in psychoses and in somnambulism[1, 2]. He says psychosis may occur under two conditions: when there is a "pathological enfeeblement of the critical censorship" or a "pathological reinforcement of the unconscious excitations", either of which may bring about the condition in which "forbidden" unconscious impulses

* Insofar as the patient perceived her repetitive bizarre behavior as ego-alien and beyond conscious control, such behavior might be thought of as "compulsive." However, the fact that these acts afforded her frank gratification renders questionable the use of the term "compulsive" . . .

and potential motor expression exist simultaneously. He feels that we do not know what conditions the phenomenon of somnambulism, and wonders why it does not occur more frequently. No answer has been suggested by subsequent research and the problem stands substantially as challenging as it was when Freud called attention to it. One can do little more than to point to additional questions.

At the center of these seems to stand the still obscure relationship between unconscious wishes and available motility. We know certain of the phenomena which presumably emerge from different variations of this relationship, but we know nothing of the specific factors which produce each. For example, we know that in certain psychoses the motor apparatus provides the means of expression of undisguised impulses, normally unconscious, as for example the carrying out of murder, rape, or arson. Yet, in others, as in the present case, unconscious impulses are given motor expression but are so heavily disguised that the original impulse cannot be discovered except by the application of specialized techniques of psychological investigation. Fundamentally the same problem arises in any attempt to understand the acting out of dreams in somnambules. It might be that all of these apparently disparate phenomena can be made more intelligible if they are studied with reference to Freud's original formulations regarding the normal relationships of unconscious impulses and "gates to motility" in the waking life and in sleep.

We come now to a discussion of the treatment technique. In a previous paper[4] there were described the essential differences between a dynamic hypnotherapy and a technique which employs hypnosis to the end of directly suggesting the suppression of symptoms; both of these methods of treatment were compared with psychoanalysis, and it was concluded that it may be possible to combine hypnotic and psychoanalytic techniques in such a way as to shorten the period of treatment without sacrificing the insight usually necessary for a permanent recovery. In that paper especial emphasis was laid on the appearance of transference phenomena and the insight derived from these phenomena and their interpretation.

In the present case, no significant transference phenomena—in the psychoanalytic sense—were manifest during the course of treatment. Beyond the special kind of "transference" which underlies any successful hypnosis, the patient's personal attitudes toward the therapist were restricted to normal respect, confidence, and cooperation. Moreover, very little material from her childhood was discussed with the patient. Her occasional attempts to revive these memories in detail were not encouraged; a resolution of acute current problems was the most we believed should be attempted at her advanced age.

A survey of the cases successfully treated by hypnotherapy in our ex-

perience shows that significant variations in technique have been employed in various types of patients. The only common elements are the production of the trance and a more productive working together of patient and therapist than exists in other types of psychotherapy. Hence one would be led to suggest that hypnotherapy is distinguished from psychotherapy mainly by the effect of the hypnotic trance in lessening the ego resistance. It appears that such resistance can largely be circumvented by hypnosis, making it possible to eliminate side-issues and thus to shorten considerably the time required for treatment. The hypnotic technique in the present instance made accessible a patient who was entirely inaccessible to any other kind of psychological approach. It made possible the recovery of directly relevant memories, the tentative formulations by both patient and therapist, and the ultimate necessary insight.

Thus it appears that hypnotherapy can accent any of the elements which may be accented in various kinds of psychotherapy. Among these are: direct suggestion, reassurance, the recovery of memories and "abreaction", and transference phenomena, with recall and insight dependent on and derived from these phenomena. The latter are more specifically psychoanalytic and should perhaps be manifestly utilized therapeutically in order that a hypnotherapy be considered "hypnoanalysis".

The particular choice of these factors must be adapted to the individual case. Thus the only requisite for hypnotherapy is that the patient be hypnotizable, and the only common factor in divergent applications of hypnosis is the circumvention of ego resistances via the hypnotic trance.

SUMMARY

The case of a 71-year-old woman with an "hysterical psychosis", treated successfully by hypnotherapy in 70 hours, is presented. The special features of the case are the advanced age of the patient, the bizarre nature of the symptom picture, the inaccessibility to other attempts at therapy, and the rapid recovery with insight through hypnotherapy.

Diagnostic problems of the case are discussed and special attention is directed to the modifiable hypnotherapeutic technique, particularly as it differed from a previously reported case in which outstanding transference phenomena enabled employment of a combined hypnotic and psychoanalytic technique.

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Love Against Hate. KARL MENNINGER, M.D. with the collaboration of JEANETTA LYLE MENNINGER. Price $3.50. Pp. 311, New York, Harcourt, Brace and Company, 1942.

This book is a most timely, interestingly written and much needed contribution to the field of psychiatric literature. The author states in his introduction that he has chosen a form of presentation which will or should be understandable to any intelligent person in preference to a more technical form suitable for medical specialists. This was a most happy choice because today nearly everyone is interested in the functioning of the personality—as well he should be.

Dr. Menninger discusses the interaction of the dynamic forces inherent in the human being during growth as they meet the impact of the attitudes of contemporary society. From this impact emotional energy is generated —the extremes of which are love and hate. He discusses the origin and the ramifications of these emotions, indicating with many case presentations the part they play in human endeavor. Even the most sophisticated reader will be impressed again and again with the original and clear examples used to show how love begets constructive behavior and how hate begets destructive results. In a short first chapter the author indicates the potential force of love for good if only parents can be induced to cultivate its growth as an antidote for the hate which so easily appears and forces human beings apart. In the next three chapters he discusses the frustrations of the child by the parents and of the woman by society, and the depreciation of women generally, including, of course, the role which the adult male plays in the total interaction of personalities. Then comes a chapter on breaking up the hostile interplay of this vicious circle. In the latter part of the book he has chapters on work, play, faith, hope and love. In these chapters various principles are set forth through which human beings may grow in emotional stature. These chapters are of equal value to the lay reader looking for inspiration and the general practitioner or the specialist looking for psychotherapeutic methods. The author has made the ofttimes dull subject of the instincts and their vicissitudes intensely interesting reading in the first part of the book and, in the last five chapters, an exceptionally thoughtful contribution toward more satisfactory ego structure. The combination makes the most practical and usable application available at present of Freudian psychoanalysis.

To read this book is an experience which should be lived through by every medical student, doctor, social worker, teacher, or worker in any other field of human relations. It is sound scientific material and yet understandable to all. The author need not have feared that it would be depreciated as "popular" science. The facts of science are no less true when they are made available to many. In fact, much of the practice in psychiatry hinges upon an understanding of the emotions and this book has true scientific value just because it gives flesh and blood, feeling and life, to the bony technical outline of human personality. Dr. Menninger flatters his colleagues by implying that they might have greater need or use for another book covering these problems purely from the technical standpoint. They need this book far more and it should be the first book for supplementary reading in every course in psychiatry in the country.

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Women After College. By ROBERT G. FOSTER and PAULINE PARK WILSON. Price $2.75. Pp. 305. New York, Columbia University Press, 1942.

A study of the problems of women in our civilization as revealed by an intensive historical, psychological and sociological investigation of 100 women is here presented. The objectives were to explore the types of problems facing college graduates to determine what contributions the college experience had made to their solution, and to experiment with the development of an adult guidance service. The most important conclusions of the study are "that both the parents and the educators of our 100 women in the elementary school, in the secondary school, and in college had almost completely ignored the evident need of these women to be prepared for certain inevitabilities of their lives." (K. A. M.)

Psychology and Human Living. By WALTER C. LANGER. Price $1.50. Pp. 286. New York, D. Appleton-Century Co., 1943.

The Commission on Human Relations of the Progressive Education Association is issuing a series of books to help young people and their parents understand human relations. This book, written by a psychoanalytically oriented psychologist, is an excellent presentation of mental hygiene from the psychoanalytic view point. There is a discussion of such topics as the need for love, the need for nurture, the need for autonomy, the need for achievement, the need for attention, etc. There are chapters on "Integration of the Personality," "Escapes," "The Return of the Repressed." This will give some idea of the content. The book is written in a clear, unaffected style, neatly printed, entirely suitable for college mental hygiene age and education level. (K. A. M.)

Handwriting Analysis: A Series of Scales for Evaluating the Dynamic Aspects of Handwriting. By THEA STEIN LEWINSON and JOSEPH ZUBIN. Price $2.00. Pp. 147. New York, King's Crown Press, 1942.

This is not a textbook of graphology but a technical guide on how to apply an exact method of measuring and rating to the characteristic qualities of handwriting. The four basic qualities of the vertical and horizontal direction, of the depth and of the form, that is, certain lengths, widths, pressures, and curvatures, are evaluated. In order to measure these correctly the authors have worked out a detailed and exact system. The values obtained in this way are entered into a number of charts and graphs and finally into a master chart. What is said about handwriting as an expressive movement and its relation to physiological and psychological forces and factors in general is quite convincing.

There is a certain vagueness about the psychological terms used. However, the analytic method as developed here is positively encouraging and suggests that further investigations along these lines might prove very interesting, as well as of practical diagnostic and prognostic value. (E. L).

INDEX TO VOLUME VII

Authors

Bartemeier, Leo H., 62
Brenman, Margaret, 163, 183, 188
Dickinson, Robert Latou, 3
English, O. Spurgeon, 199
Gill, Merton M., 6, 114, 163
Knight, Robert P., 25, 114, 148, 188
Kubie, Lawrence S., 172
Lewin, Bertram D., 80
Lozoff, Milton, 114
Maier, Norman R. F., 141
Mead, Margaret, 57, 137
Menninger, Karl, 36, 47, 89, 199
Menninger, William, 15, 129
Rapaport, David, 80, 99, 106, 114
Reichard, Suzanne, 93, 99, 183
Reider, Norman, 45
Robbins, Lewis L., 41
Schafer, Roy, 93
Sterba, Richard, 69

Subjects

Abnormal behavior, in the rat, 141–147
Anthropological methods, in war psychology, 137–140
Anxiety hysteria, treatment by hypnoanalysis, 163–171
Association test, 118, 123, 126
Babcock Intelligence Test, 115, 120, 124
Bellevue Scale, scatter, clinical significance of, 93–98, 115, 124, 127
Birth control, psychiatric aspects of, 36–40
Boarding home plan, Southard School, 76–79
Book Notices, 80, 84–86, 156–158, 199–200
Clinical findings, compared to psychological test results, 114–128
Clinical problems in military psychiatry, 134–136
Clinical psychology, in psychiatric clinic, 89–92
Concept formation, testing of, 92, 99–105, 116, 122, 126
Contraception, psychiatric aspects of, 36–40
Convulsive disorder, induced in rats, 141–147
  psychiatric study of case, 62–68
Dysmenorrhea, 8–11
Emotional attitudes, post-partum, 23
  toward becoming pregnant, 16–18
  toward pregnancy, 18–23
Emotions and Memory, review, 80
Epilepsy, psychiatric study of case, 62–68
Feminine development, psychosexual factors in, 27–29
Fixations, abnormal, in rats, 142, 144–146
Food habits, problem of, 57–61
Frigidity in women, 25–35
  degrees of, 31–32
  prevention of, 32–33
  treatment of, 34
Functional disorders, in sexual life of women, 25–35
Gynecology, psychiatry and, 3–5, 47–55
Hanfmann-Kasanin Test, in concept formation testing, 103–104
Hypnogogic reverie, in recovery of repressed data, 172–182
  methods of producing, 173
Hypnosis, research in, 161–198
Hypnotherapy, employing psychoanalytic principles, 163–182, 188–198
  in anxiety hysteria, 163–171
  in hysterical psychosis, 188–198
  in menstrual disturbances, 8, 10–11
  in mental illness of aged person, 188–198
Hypnotizability, prediction of by Rorschach test, 183–187
Love Against Hate, review, 199
Menarche, following one psychotherapeutic interview, 45–46
Menninger Foundation, The, activities of, 56, 76–79, 89–92, 161–162
Menstruation, functional disturbances of, 6–13
  psychological meanings of, 6–8
  onset, 45–46
Metapsychology of morale, 69–75
Military personnel selection, psychological tests and, 114–128
Military psychiatrist, 129–136
Military psychology, comparative, 139–140
Morale, metapsychology of, 69–75
Organic gynecological conditions, emotional factors in, 47–55
Pregnancy, emotional factors in, 15–24
  following adoption, 41–44
Pre-menstrual tension, 11
Psychiatry, military, 129–136
Psychoanalysis, Topeka Institute for, 81–83
Psychoanalytic contributions, to changing food habits, 57–61
  to hypnotic technique, 167–171

Psychological tests, military personnel selection and, 114–128
results compared to clinical findings, 114–128
Psychology, clinical, in psychiatric clinic, 89–92, 114–128
Psychoneuroses, in war, 148–155
Psychosexual factors, in feminine development, 27–29
Psychosomatic research, 56
Psychotherapy, as treatment for menstrual disturbances, 10, 45–46
Rat, abnormal behavior in, 141–147
Repressed data, recovery by hypnogogic reverie, 172–182
Rorschach Test, 114–128
in prediction of hypnotizability, 183–187
Roster of medical and nursing staff members and former members now in military service, 87, 159–160
Scatter, on Bellevue Scale, significance of, 93–98
Seizures, abnormal, in rats, 141–144
Sexual anxiety, women's reaction to, 29–31
Similarities Test, in concept formation testing, 101
Sorting Test, in concept formation testing, 101–103
Southard School, boarding home plan of, 76–79
Sterility, in women, psychological study of, 41–44
Szondi Test, 117–127
Thematic Apperception Test, clinical application of, 106–113, 114, 118, 122, 126
Topeka Institute for Psychoanalysis, 81–83
Transference, in hypnoanalysis, 167–169
War neuroses, diagnosis of, 148–150
psychopathology of, 150–151
treatment of, 151–155
War psychology, anthropological techniques in, 137–140